Republic of Sudan

Stakeholder Engagement Plan (SEP)

Sudan COVID-19 Emergency Response Project

Parent (P174352) and Additional Financing (P176824)

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List of Abbreviations and Acronyms

CERC	Contingency Emergency Response Component
E&S	Environmental and Social
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standard
FMOH	Federal Ministry of Health
GBV	Gender Based Violence
GoS	Government of Sudan
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCFs	Health Care Facilities
ID	Identification Document
IDPs	Internally Displaced Persons
IPs	Indigenous Peoples
IT	Information Technology
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
OHS	Occupational Health and Safety
PAPs	Project-Affected Parties
PIU	Project Implementation Unit
SAGE	Strategic Advisory Group of Experts
SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SH	Sexual Harassment
SIA	Social Impact Assessment
SSAHUTLC	Sub-Saharan African Historically Underserved Traditional Local Communities
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

1. Introduction/Project Description

Since the outbreak of the coronavirus disease (COVID-19) on mid-March, the Government of Sudan (GoS) has taken several measures to control the spread of the pandemic. These started with a declaration of a health state of emergency and closing of Khartoum international airport, permitting only humanitarian, medical emergency and some cargo flights. Land and sea borders are also closed. All schools and markets have also been closed, with all public gatherings, such as weddings and social events banned. Domestic flights and inter-state public transportation have since been halted, with a country wide curfew. The GoS has set up two isolation centers with 120 beds and 28 ventilators for patients with symptoms. In addition, the Government developed and endorsed a national COVID-19 Preparedness and Response Plan on March 28 with an estimated required budget of $100million. Specifically, Sudan's COVID-19 response plan focuses on the following areas: (i) strengthen the coordination leadership capacity to control and minimize the spread of COVID-19 in Sudan; (ii) build national capacity to detect, trace and confirm cases through strengthening the surveillance, rapid response and laboratory capacities; (iii) build national capacity to isolate and manage cases through establishment of treatment centers, including intensive care, training health workers and Rapid Response Teams (RRTs) and improving the Infection Prevention and Control (IPC) measures; (iv) support measures that prevent further spread of the virus through effective risk communications and other control measures; and (v) quarantine exposed and suspected cases of COVID-19 in especially equipped areas.

The Sudan COVID-19 Response Project (including its additional financing components) aims to strengthen the Government of Sudan's capacity to be prepared to respond to the COVID-19 outbreak. **The specific objectives of the project, aligned with the national COVID-19 Plan, are to**: (i) strengthen case detection and confirmation and conduct contact tracing; (ii) improve clinical care capacity; (iii) raise public awareness and promote community engagement; and (iv) bolster coordination, planning, logistical support, and reporting. While the focus is on the coronavirus response and preparedness, the activities to be supported are expected to have cross-cutting benefits for addressing other disease outbreaks.

Being a World Bank (WB)-financed, the project will thereby adhere to the World Bank's Environmental and Social Framework (ESF). For this purpose, the project has undergone an initial screening against the ***10 Environmental and Social Standards (ESSs)*** that are defined in the ESF. According to the screening, Environmental and Social overall risks and impacts have been found substantial, and thus, **respective assessments and plans will be developed, in particular, a Stakeholder Engagement Plan (SEP) according to the requirements of ESS10 – Labor and Working Conditions.**

1.1. The Sudan COVID-19 Emergency Response Project

Component 1: Emergency COVID-19 Response

Sub-Component 1.1: Case Detection, Confirmation and Contact Tracing (parent project and proposed AF)

This sub-component, including AF scaling up, will help (i) strengthen disease surveillance systems, public health laboratories, and epidemiological capacity for early detection and confirmation of cases; (ii) combine detection of new cases with active contact tracing; (iii) support epidemiological investigation; (iv) strengthen risk assessment, and (v) provide on-time data and information for guiding decision-making and response and mitigation activities. Support under this sub-component will include but not be limited to the following areas:

- Training of core teams and district teams in rapid response and contact tracing;
- Training of laboratory staff for testing of COVID-19 suspected cases; and
- Procurement, service and maintenance of COVID-19 diagnostic equipment including purchase of testing kits, reagents, sample collection materials and cartridges, related accessories and equipment.

The surveillance system will be strengthened to detect COVID-19 and other outbreak-prone diseases including climate-induced outbreak prone diseases.

Sub-Component 1.2: Health System Strengthening (parent and proposed AF)

The health system strengthening sub-component includes the following five mutually reinforcing areas:

1. It will strengthen Sudan's health system to provide optimal medical care to COVID-19 patients while minimizing risks for other patients and health personnel. The project will support Sudan's clinical care capacity, the adoption of measures and protocols to treat COVID-19 patients and investments to ensure appropriate Infection Prevention and Control measures. Activities to be supported under this sub-component include (i) establishing isolation capacity in hospitals designated to treat COVID-19 patients, (ii) adapting existing structures to enable triaging, (iii) procuring and distributing personal protective equipment, (iv) providing drugs, medical equipment and supplies to comply with WHO standards for COVID-19 supportive treatment, (v) developing and validating treatment guidelines, and (vi) providing clinical training of health personnel to treat COVID-19 patients.

2. The project, including AF scaling up, will enhance the system preparedness for future COVID-19 waves along with other disease outbreaks such as cholera and acute watery diarrhea. This will cover supporting the EOC and information systems. through (i) specialized training to EOC staff, and ii) strengthening call/hotline centers and upgrading information systems equipment.

3. Third, it will support nationwide risk communication and community engagement campaigns to raise awareness of COVID-19 and other pre-existing health priorities. The project will support risk communication and community engagement with key decision makers and stakeholders, including community and opinion leaders. Various methods for community sensitization including mass media and social media will be key in bringing the message to individual households. The activities to be supported under this include: (i) community engagement activities, (ii) conducting risk assessment to identify hot spots, (iii) social media review to identify rumors and target messages, (iv) the development of broadcast messages and communication support materials including billboards, epidemiological bulletins and TV documentaries, and (v) airtime payment for broadcast of infomercials and civic education.

4. The project will support leadership and coordination activities across different ministries and departments at the federal and state levels. This includes provision for (i) the development of guidelines, regulations and laws, (ii) costs of periodic multi-stakeholder meetings and information exchange, and (iii) operational costs incurred in coordinating actions and reporting mechanisms between health, security, customs and immigration authorities.

5. The project will support laying the foundations for managing the supply and cold chains along with the distribution of COVID-19 effective and internationally approved vaccines.

Sub-component 1.3: Vaccine procurement and deployment (for the proposed AF)

Vaccine purchasing will be done through Component 1 of the Global COVID-19 MPA (SPRP). The support for vaccines when available, which was anticipated in the initial Global COVID-19 MPA, will be added as part of the containment and mitigation measures to prevent the spread of COVID-19 deaths under Component 1: Emergency COVID-19 Response. Sudan will potentially use the options of: (i) direct purchase from vaccine manufacturers; (ii) purchase of excess stocks from other countries that reserve excess doses; and/or (iii) purchase through the COVAX Facility for vaccine purchase and financing mechanisms[1]. Given the recent emergency of COVID-19, there is no conclusive data available on the duration of immunity that vaccines will provide. While some evidence suggests that an enduring response will occur, this will not be known with certainty until clinical trials follow participants for several years. As such, this proposed AF will allow for re-vaccination efforts if they are warranted by peer-reviewed scientific knowledge at the time. In the case that re-vaccination is required, limited priority populations (such as health workers and the elderly) will need to be targeted for re-vaccination given constraints on vaccine production capacity and equity considerations (i.e., tradeoffs between broader population coverage and re-vaccination). As a prudent and contingent measure, budget for funding has been retained for re-vaccination, if needed of such a subset of the population.

To support the Government's vaccination planning, the proposed AF will finance upfront technical assistance to support Sudan to establish institutional frameworks for the safe and effective deployment of vaccines. These include: (i) guidelines for intra-country vaccination allocation; (ii) guidelines/protocols related to ensuring that there is no forced vaccination and that any mandatory vaccination program (such as entry to schools) is well designed including regarding consent and follows due process for those who choose to opt out; and (iii) the strengthening of accountability, grievances, and citizen and community engagement mechanisms including strengthening of such systems to function in the event of climate hazards.

The proposed AF will support investments to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale. To this end, the proposed AF is geared to assist the GoS, working with WBG, WHO, UNICEF and other development partners, to overcome bottlenecks as identified in the COVID-19 vaccine readiness assessment in the country. This subcomponent will support deployment priorities identified in the NVDP. These include but no limited to: (i) logistics along the supply chain, including climate friendly cold-chain equipment; and (ii) enhancing waste management capacity including trainings with modules on health care waste management and climate friendly waste management, with attention to waste management in flood-prone areas. Demand creation and RCCE interventions are critical to the success of the COVID-19 vaccination efforts. The proposed AF will also support: (i) well targeted communication campaigns through mass media, social media and community outreach to improve knowledge and correct myths and misconceptions that cause vaccine hesitancy; (ii) tracking and monitoring of correct knowledge of COVID-19 vaccination and vaccination against climate-induced outbreak prone diseases, and identify

[1] On April 26, Sudan has formally expressed interest to purchase vaccines through COVAX cost sharing arrangements

views, perceptions, norms and attitudes in order to design correct messaging and effective community outreach strategies; and (iii) facilitation of civil society and citizen engagement mechanisms for feedback, accountability and grievance redressal.

The proposed AF will support vaccination of 9.0[2] percent of the country's population beyond the twenty percent covered by the COVAX Facility, in accordance with the priority groups summarized in Table 3 below.

Sub-component 1.4: Solarization of health and vaccine storage facilities in Sudan (for the proposed AF)

Nearly 20-40 percent of Sudan's storages of health facilities have no access to the grid and rely on expensive diesel generators. The remaining have access to the electric grid; however, the power grid in Sudan experiences frequent and extended power outages. With the ongoing COVID-19 pandemic and the need to facilitate COVID-19 cold chain development, solarization of cold storage facilities are a critical priority. The AF will be supplemented by a grant of US$900,000 from the Energy Sector Management Assistance Program (ESMAP) to support urgent need of solar photovoltaic (PV) electricity services to: (i) selected cold storage facilities to ensure the vaccines are kept at the required temperature at the level of localities; and (ii) selected health facilities to ensure vaccines are kept at the required temperature at the point of delivery. The major planned procurement activities under the ESMAP grant will includes but not limited: a contract for the supply and installation of a solar battery-backup system and required wiring reconfiguration; training of local technicians on basic system operation and maintenance; and a contract for the procurement of the Solar Direct Device (SDD) refrigerators.

Component 2: Implementation Management and Monitoring and Evaluation (parent and proposed AF)

To ensure equitable access to vaccines, especially by targeted vulnerable populations, there is a need for close monitoring of the vaccine administration process and putting in place mechanisms to prevent some segments of the population taking advantage of others; in this regard, this component will support: (i) strengthen monitoring and reporting of adverse occurrences such as elite capture, GRM and citizen engagement activities; (ii) implementation of the ESCP; (iii) project coordination and supervision of project activities; and (iv) an independent assessment of the implementation of the Sudan's COVID-19 response. Climate activities supported by this project will also be monitored within this component.

Component 3: Contingent Emergency Response (CERC)

A zero cost CERC will provide support for future emergency responses. Following an eligible crisis or event, clients may request the Bank to re-allocate project funds to support an additional emergency response. The CERC would draw from the uncommitted grant resources under the project to cover emergency response. CERCs can be activated without needing to first restructure the original project, thus supporting rapid implementation. To facilitate a rapid response, formal restructuring is deferred to within three months after the CERC is activated.

These components will be complemented by a World Bank Executed Trust Fund which will cover operational support and analytical and technical assistance provided by the World Bank throughout project implementation.

[2] This figure might vary based on the evolving COVAX cost-sharing arrangements and the availability of new WHO authorized vaccines

1.2. Potential Environmental and Social Risks and Impacts

The following are key social risks expected during the implementation of the project:

1. Occupational Health and Safety (OHS) risks: Potential risks during the rehabilitation activities at the Health Care Facilities (HCFs) include falling, tripping, slipping, and over-exertion from manual handling of heavy objects, injuries from working on heights, working in confined places, burns from hot works (welding), electrocution, injury from moving machinery and dust from construction vehicles. On another hand, HCFs' workers are also exposed to daily risks and impacts of varying nature and scale during operations at HCFs, including exposure to injuries from manual handling of objects and patients, such as sprains and strains, exposure to hazardous materials, wastes, radiation, and risk of fire. Of particular concern is the prolonged exposure of workers to COVID-19 infections from patients and/or from their waste, cloths, and linen, in particular at quarantining, isolation centers, and laboratories, as well as at screening posts. Workers, in particular health care personnel, nurses, and cleaners, may be asked to work overtime to respond to the COVID-19 outbreaks. Women in particular, if they are single heads of household and have child-care duties may have difficulties responding to requests for overtime. Health care and other staff, including cleaners, or workers in the limited upgrade/rehabilitation may experience respiratory symptoms, or may contract COVID-19, thus, they will fear not getting paid and will continue to show up at work. Women health workers, may face mental issues or burnout as result of an outbreak. There is a minor risk of child labor engagement working as cleaners in medical facilities or transporting medical/non-medical supplies or equipment. Adverse impacts on workers' mental and physical wellbeing due to these risks are expected moderate and direct on the individual level.

2. Community health and safety risks: indirect risks related to the spread of COVID-19 among the population at large, and especially for the most disadvantaged and vulnerable populations, such as the elderly, children, poor households, persons with disabilities including physical and mental health disabilities, and IPs/SSAHUTLCs, due to poor training, communication and public awareness related to the readiness and response to the new COVID-19. In particular, the project activities could contribute to COVID-19 cases (if not managed well), when transporting contaminated waste, lab tests, lab workers, or people who tested positive. Health workers may face discrimination and harassment when going back to their communities due to people's fear in contracting the virus, frustrations over medical care or misinformation. Other social risks, yet to be expected, are vaccination hesitancy, due to disinformation, and rumors about efficacy of some vaccine brand names. Screening of people entering the country, could lead to abuse of power by law enforcement, fear from community members (especially the elderly), and potential for discriminating marginalized groups. Impacts seen in this area are expected to be high, direct on individuals, but indirect on communities.

3. Gender Based Violence (GBV), Sexual Exploitation and Abuse (SEA), and Sexual Harassment (SH) Risks: this risk includes violence against women and children related to healthcare workers and people in quarantine. Quarantine measures, together with fears over COVID-19, livelihood impacts as a result of any restrictions in movement, social isolation and increased economic pressures and loss of jobs (informal or formal sector) may exacerbate household tensions and, thus, increase cases of GBV/SEA/SH. Project staff (civil servants and outsourced staff/contractors) may be involved in misconduct behaviors impacting women and children at the local level. Impacts are therefore, seen moderate, direct on individuals, but indirect on communities.

4. Risk of Social Exclusion: Elite capture will be more visible during early planning and implementation of vaccination programs, where vaccination shares for Sudan are still under expectation. Target communities may experience exclusion from planning and designing of

measures required to screen against COVID-19 and associated information releases, as well as being excluded from the national COVID-19 vaccination program itself; due to inherent poor inclusion and lack of outreach opportunities, and likely for their political stands. People who possess vulnerability characteristics, such as the poor, the elderly, people with disabilities, and households headed by single women, as well as the IPs/SSAHUTLCs, are among the most affected. Those people are less likely to have access to internet, or be active on social media. Consequently, they will be inadequately communicated about the pandemic risk, and if got infected, might be challenged to access health care and project services. Such exclusion would also occur, because of the limited access to COVID-19 testing locations and other public health services, due to remoteness and inability to travel as per governmental movement restrictions. Additionally, communication materials may not reach out the most vulnerable, in particular, the elderly, IPs/SSAHUTLCs, and workers from the informal sector, a lot of whom are women, who tend to have lower levels of education, lower income, and may have lower literacy. Impacts are seen high, indirect on target communities.

5. Risk of Social Stigma: this is the social stigma that could be precipitated by COVID-19 both to and from sufferers, including: risk of fear and/or stigma towards the virus, which may make people hide symptoms, avoid getting tested and even reject hygiene measures or wearing PPE (or masks if recommended). It also includes health workers, who may suffer stigma, in particular when coming back to their communities, as they may be seen as potential "carriers". Impacts are seen moderate and indirect on infected individuals.

1.3. Legislative and Policy Requirements

Article 39 (1) of the Sudan Interim Constitution provides that 'every citizen shall have an unrestricted right to freedom of expression, reception and dissemination of information, publication, and access to the press without prejudice to order, safety or public morals as determined by law'. Further, Article 27(3) of Sudan National Interim Constitution provides that 'all rights and freedoms enshrined in international human rights treaties, covenants and instruments ratified by the Republic of the Sudan shall be an integral part of this Bill'[3].

The World Bank's Environment and Social Standard 10 sets out that a Borrower has to engage with stakeholders as an integral part of a Project's environmental and social assessment and project design and implementation. The nature, scope and frequency of the engagement should be proportionate to the nature and scale of the Project. Consultations with stakeholders have to be meaningful and be based on stakeholder identification and analysis, plans on how to engage stakeholders, disclosure of information, actual consultations, as well as responses to stakeholder grievances, and reporting back to stakeholders.[4]

2. Stakeholder Identification and Analysis

Project stakeholders are defined as individuals, groups or other entities who:

1. Are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and
2. May have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

3 Sudan National Interim Constitution 2005, art 27(3).

4 World Bank, Environmental and Social Framework. Setting Environmental and Social Standards for Investment Project Financing, August 2016.

Cooperation and negotiation with the stakeholders throughout the Project development often also require the identification of persons within the groups, who act as legitimate representatives of their respective stakeholder group, i.e. the individuals who have been entrusted by their fellow group members with advocating the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insight into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks. Verification of stakeholder representatives (i.e. the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can be representing their interests in the most effective way.

2.1. Methodology

In order to meet best practice approaches, including in line with COVID-19 restrictions and related parameters the project will apply the following principles for stakeholder engagement:

- Openness and life-cycle approach: public consultations for the project will be arranged during the whole lifecycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
- Informed participation and feedback: information will be provided to and widely distributed among all stakeholders in an appropriate format that is accessible and understandable, taking into account cultural sensitivities, literacy levels of stakeholders, and special needs of stakeholders with disabilities, and stakeholders that are members of other vulnerable groups opportunities are provided for communicating stakeholders' ongoing feedback, for analyzing and addressing comments and concerns;
- Inclusiveness and sensitivity: stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times encouraged to be involved in the consultation process. The project will provide equal access to information to all stakeholders taking into consideration cultural sensitivities and literacy levels. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, youth, people with disabilities, elderly and the cultural sensitivities of diverse ethnic groups. All consultations will be tailored to ensure the participation and involvement of the IP/SSAHUTLC communities.

For the purposes of effective and tailored engagement, stakeholders of the proposed project can be divided into the following core categories:

- **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
- **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and

- **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project as compared with any other groups due to their vulnerable status[5], and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

2.2. Affected Parties

Affected Parties include local communities, community members and other parties that may be directly affected by, or otherwise experience direct impacts from the Project. Specifically, the following individuals and groups fall within this category:

- People enrolled in the vaccination program;
- COVID-19 infected people;
- People under COVID-19 quarantine;
- Relatives of COVID-19 infected people;
- Relatives of people under COVID-19 quarantine;
- Neighboring communities to laboratories, quarantine centers, and screening posts;
- Workers at construction sites of laboratories, quarantine centers and screening posts;
- People at COVID-19 risk (travelers, inhabitants of areas where cases have been identified, etc.);
- Public Health Workers;
- Municipal waste collection and disposal workers;
- Medical waste collection and disposal workers;
- Direct workers at federal and state MOH;
- Other Public authorities participating in the project;
- Airlines/ international transport, and border control/ Customs staff;
- Staff of UN agencies, such as World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the World Food Program (WFP), and the United Nations Populations Fund (UNFPA); and
- Local community leaders, including chiefs, headmen and headwomen, especially for communities as identified for application of ESS7.

2.3. Other Interested Parties

The projects' stakeholders also include parties other than the directly affected communities, including:

- Local vendors of project supplies and services
- Traditional media, including newspapers, radio, and television networks;
- Participants of social media;
- Private Sector Federation;
- Schools and nurseries;
- Politicians, religious institutions, and academia;
- Other national and international health/ social organizations;
- Businesses with international links; and
- The public at large.

[5] Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, color, gender, gender orientation, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

2.4. Disadvantaged/ Vulnerable Individuals and Groups

It is particularly important to understand whether project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups[6], who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups on infectious diseases and medical treatments in particular, be adapted to take into account such groups or individuals' particular sensitivities, concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g. minorities or fringe groups), dependence on other individuals or natural resources, etc. Engagement with the vulnerable groups and individuals often require the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

Within the Project, the vulnerable or disadvantaged groups may include and are not limited to the following:

- The elderly;
- Women and children;
- The illiterate people;
- People with disabilities;
- IP/SSAHUTLC communities and minorities; and
- Refugees and IDPs

Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate.

3. Stakeholder Engagement Plan

3.1. Summary of Previous Stakeholder Engagement

Public consultation is required by the WB's ESS10 (Stakeholder Engagement and Information Disclosure). In fact, it is required in all stages of the Project. The consultation process would entail identification/mapping of project stakeholders as a first step. Public consultations aim to inform stakeholders about the Project and its associated schedules and progress, and collect views (interests and concerns) about expected E&S risks and impacts, during implementation.

The urgency of the Project, combined with restrictions on people gatherings, due to spread of COVID-19 has limited the ability to conduct public consultations in the field. In line with developments of COVID-19, the stakeholder engagement and consultation activities will be designed to fit meaningful consultation purposes.

Up to date of preparing this report, public feedback could only be collected through social media and other digital channels. The project team at PIU has succeeded in reaching out the public and experts through announcements via FB FMOH official page as well as conducting virtual meetings with subject matter experts. The following provide more information about these opportunities and results collected:

[6] Vulnerable groups include: children, women, the elderly, the disabled, the marginalized, migrants, refugees, displaced, and others

1. Vaccination announcement

To fulfill the urgent needs of collecting public views, the project team at PIU has referred to the official page of the FMOH, and extracted public feedback on the announcement of the first COVAX consignment that has arrived to Sudan on the 4th of March 2021. The FMOH officials have announced the reception of 820,000 doses of the vaccine. The announcement also highlighted the big efforts done for handling and managing the consignment, and officially stated the strategy for vaccination priorities as following: the most vulnerable groups, health and medical staff, then the elderly, and finally the entire population. The announcement was concluded by extending gratitude to all national agencies and international partners, who helped in this important humanitarian effort.

The post has shown the following public reaction:

- People requesting senior management to be transparent about the pandemic situation in the country, as well as to be just while distributing and applying the vaccine
- Some people has highlighted the women labor, and that the government should focus on men for labor instead
- COVID-19 is not the biggest issue in the county. Sudanese people are dying from starvation, Malaria, and other shortages of essential life requirements, such as electricity and fuel
- Some comments gave false information about the vaccine, by calling it "the vaccine of death"
- Some other commenters were criticizing staff of the FMOH and customs dept. for not putting their face masks on while on mission, as shown in some of the site photos
- The government should also take the public welfare and livelihood improvement more seriously

2. Consultation Questionnaire:

The project team at PIU has also used the official FB page of the ministry to announce the launching of the project. In order to touch base with public views about project's objectives, activities, and possible social issues, a simple questionnaire was prepared and linked to the project post (7 March – 10 March 2021, on Facebook). The questionnaire was preceded by a summary on the project objectives and key benefits (embedded in the post in Arabic language), and included a Yes/No eight social-related questions. The purpose of the questions was to understand the degree of significance of each of the possible social issues, by a public lens.

The post included a link to the following questions:

1. Please give us your thoughts about the project.
2. Do you think that the project would have adverse impacts on its workers' occupational health and safety?
3. Do you think that project's interventions would increase numbers of COVID-19 positive cases among workers of the health care system? Or would it help transmit the virus to people who visit health care centers in general?
4. Do you expect that vulnerable people are more susceptible to contracting the virus than others? Vulnerable people partly refer to: The Elderly, the Women, the Children, the Disabled, and ethnicity groups in rural areas of the country.

5. Do you expect increasing rumours and misinformation about safety/efficiency of the COVID-19 vaccine? Or increasing suspicious thoughts about the adopted measures?
6. Do you expect increasing social stigma as a result of contracting the virus?
7. Do you think the project will cause tension between communities, as a result of not including all in the vaccination program, or because of certain delays within the campaign?
8. Do you think that the project will increase cases of gender-based violence, sexual exploitation and abuse, while attending the vaccination points and/or health care/isolation centers?

A total number of 91 persons have participated in answering the above questions, representing 71 males and 20 females. Participation included people from Khartoum, Al-Gadarif, Gezira, Red Sea, North Kurdufan, and North Darfur. The following table summarizes answers on the above questions:

Table 1: Answers to public consultation questionnaires – results analysis

Q	Area of concern	Yes (%)	No (%)	Probably (%)	Evaluation
2	Workers' OHS	9.9	71.4	18.7	Lower significance
3	Virus transmission (workers vs. the public)	11.0	70.3	15.4	Lower significance
4	Impacts on vulnerable groups	51.6	26.4	22.0	Higher significance
5	Rumours and misinformation/ mistrust	74.7	15.4	9.9	Higher significance
6	Social stigma	17.6	57.1	24.2	Moderate significance
7	Community tension	36.3	35.2	27.5	Moderate significance
8	GBV/SEA/SH	17.6	62.6	19.8	Lower significance

As for question number 1, the project team at PIU has collected the following interests and concerns:

- Many participants highlighted the importance of the project in strengthening the Sudanese national health care system. Although coming late, it will provide assistance. Specific points for improvement included the early screening and detection of the virus at the entry points to control the spread of the new variants, and effective prioritization of vulnerable target groups, and increasing preparedness and resilience against similar emergencies in the future.
- The audience is asking for detailed figures concerning the improvement of health care system, numbers of additional beds, screening and isolation centers, as well as numbers of whom to be vaccinated. Other interviewees urged the need for integrating the project in the overall development process in the health sector.
- Participants have raised the issue of scheduling the vaccine, the screening and vaccination mechanisms, as well as prioritization.
- Participants have raised the issue of reaching out people in remote areas, particularly those, who don't have access to internet and social media.
- Participants have raised the issue of poor administrative infrastructure, particularly with the health care system

3. Virtual Expert Meeting:

Furthermore, the project has successfully conducted, on the 10th of March 2021, a virtual meeting with specialists from the health care sector. The meeting was organized virtually by the project's PIU and hosted at the FMOH. A total number of 18 environmental, social and health experts (12 females and 6 males) have participated in the virtual meeting. Part of the audience has attended the meeting table with necessary health precautions, and others were enabled to join remotely. The PIU staff presented and described the project to the audience and highlighted the positive impacts foreseen from implementing the project. Specifically, the following issues were discussed:

1. Objectives and requirements of stakeholder/ public consultation, according to WB's ESF
2. The required safeguard documents as a pre-requisite for launching the project
3. Vaccination prioritization, announcement, community acceptance, and implementation on the ground
4. Medical waste management
5. Vulnerable groups and outreach campaigns
6. More focused discussions on school closures and child labor
7. Awareness programs at the country level
8. Possible social and environmental impacts
9. Rumours, misinformation, and the pandemic ignorance
10. The requirement for having a functional GRM, and objectives

A full meeting record can be found in Annex I.

For next rounds of consultation, the Project is planning to conduct more virtual meetings with key stakeholders within the national project team, including health, E&S experts, academia, NGOs, representatives of communities and vulnerable groups, all in coordination with FMOH's PIU and in compliance with applicable social distancing and protection measures against COVID-19. Public feedback on social impacts and possible mitigation measures will continue to feed in the updated versions of this SEP.

3.2. Summary of Project Stakeholder Needs and Methods, Tools & Techniques for Stakeholder Engagement

The WHO "COVID-19 Strategic Preparedness and Response Plan OPERATIONAL PLANNING GUIDELINES TO SUPPORT COUNTRY PREPAREDNESS AND RESPONSE" of the year 2020, outlines the following approach in Pillar 2 – Risk Communication and Community Engagement, which will be the basis for the Project's stakeholder engagement:

"It is critical to communicate to the public what is known about COVID-19, what is unknown, what is being done, and actions to be taken on a regular basis. Preparedness and response activities should be conducted in a participatory, community-based way that are informed and continually optimized according to community feedback to detect and respond to concerns, rumors and misinformation. Changes in preparedness and response interventions should be announced and explained ahead of time and be developed based on community perspectives. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust."

The project includes considerable resources to implement the above actions. The details will be prepared as part of the respective Sudan-specific Risk Communication and Community Engagement Strategy, and consequently this SEP will be updated to outline how the above points will be implemented for the different areas to be funded by the Project. Consultations will be done on final ESMF and SIA.

3.3. Proposed Strategy for Information Disclosure and Consultation Process

In terms of methodology, it is critical that the various project activities are inclusive and culturally sensitive, thereby ensuring that the vulnerable groups outlined above will have meaningful opportunities to participate in Project design and benefits. An inclusive information disclosure strategy will include household-outreach and focus-group discussions in addition to village consultations, ensuring usage of languages appropriate for the respective affected communities, the use of verbal communication or pictures instead of text where literacy is an issue, etc. Likewise, the project will need to adapt the methods of stakeholder engagement to COVID-19 physical distancing and other national requirements with recognition that the situation is developing rapidly. The project will have to adapt to different geographic requirements as well.

The targeted stakeholders include all affected parties as identified above. The consultations will cover various topics and use different methods as per the checklists developed by WHO for risk communication and community engagement[7]. To address the challenge of uptake of protective behaviors, the project will develop short multimedia pieces that present key information (e.g., explain the disease symptoms, transmission, how to protect oneself and what to do if someone gets sick) and that can be shared online and transmitted, translate materials into relevant languages and adapt them to appropriate literacy levels.

To address concerns, attitudes, beliefs, and barriers to following health guidance, the project will have hotlines operated by medical team, who can answer calls and engage on social media, and call-in radio programs where information is provided, and the public can ask questions on TV. The FMOH will have an established and consistent feedback mechanism between communities and the emergency response team and to provide actionable guidance for emergency responders to better meet the health protection needs of communities. The FMOH will engage through social media: proactively inform audiences and collect and answer all questions. The engagement through radio programs so that people can call in and ask questions. Identify community influencers (e.g., community leaders, religious leaders, health workers, traditional healers, alternative medicine providers) and networks (e.g., women's groups, community health volunteers, youth associations, religious groups, unions, and social mobilizers for polio, malaria, HIV) that can help with community engagement. The FMOH cater for those with special information and engagement needs for people who are disabled or illiterate.

[7] https://www.who.int/publications/i/item/covid-19-global-risk-communication-and-community-engagement-strategy

Table 2: Proposed Stakeholder Engagement Plan

Project stage	Topic of consultation	Method used	Timetable: Location and dates	Target stakeholders	Responsibilities	Budget (USD per year)
Project Preparation/ inception, and update of instruments	Project design elements	Through distributing checklists + phone calls + virtual meetings	Project preparation period	Representatives of Government (health sector, in particular), Project Management offices, international and national partners, as well as key community/religious leaders	Project Preparation team in Collaboration with concerned offices	Estimated at 18,000
	1. Project design, Environmental and Social Risks, Mitigation Measures, GRM and SEP	Distributing checklists + phone calls + physical meting (adopting COVID-19 measures) + virtual meetings	Project preparation period	Representatives of Government (health sector, in particular), Project Management offices, international and national partners	Project Preparation team in Collaboration with concerned offices	Estimated at 18,000
	2. Project design, Environmental and Social Risks, Mitigation Measures, GRM and SEP	Community Meetings FGDs and interviews (adopting COVID-19 measures) or virtual meetings (if applicable)	Project inception	Representative Members of Selected Communities, Elders, disabled and Women Group, religious/political community leaders, and traditional organizations	Project preparation team in collaboration with concerned offices + local NGOs in the field	Estimated at 36,000
Project Implementation (incl. vaccination program)	Project implementation Progress Review meetings	Community Meetings + physical information distribution (adopting COVID-19 measures) or virtual meetings (if applicable)	Quarterly	Representative members of selected communities, the elderlies, disabled and Women Groups, religious and political/ community leaders, traditional organizations, Representatives from health/ pharmaceutical and academia sectors	Locality/County level PIUs + local NGOs for outreach	Estimated at 100,000
Project phase out	Exit strategy preparation	Community Meetings (adopting COVID-19 measures) or virtual meetings (if applicable)	Last year of the project	Representative members of selected communities, the elderlies, disabled and Women Groups, religious and political/ community leaders, traditional organizations, Representatives from health/ pharmaceutical and academia sectors + representatives of the WB + international partners	Locality/County level PIUs + local NGOs for outreach + support of National Project coordination team	Estimated at 36,000

3.4. Future of the Project

Stakeholders will be kept informed as the project develops, including reporting on project environmental and social performance and implementation of the stakeholder engagement plan and grievance mechanism. This will be important for the wider public, but equally and even more so for suspected and/or identified COVID-19 cases as well as their relatives.

4. Resources and Responsibilities for Implementing Stakeholder Engagement Activities

4.1. Resources

The Federal Ministry of Health will be responsible for, and oversees, the implementation of stakeholder engagement plan and related stakeholder engagement activities. The budget for the SEP will be covered as part of the RCCE under Component 1- Emergency COVID-19 Response.

4.2. Management Functions and Responsibilities

The institutional, implementation and coordination arrangements for the project will leverage existing platforms and seek to strengthen capacities and systems for implementation of disease outbreak response and preparedness capacity. **The FMOH** will be supported to handle its policy and strategy formulation roles and responsibilities, ensuring oversight and coordination.

The Coronavirus National Taskforce (NTF) will coordinate the national response and provide strategic guidance for the implementation of the national program. The taskforce includes representatives of key ministries and government agencies, international and national organizations, UN agencies; as well as the main development partners active in the health sector, hence it is well placed to provide general oversight and advice. The NTF is assisted by an **Expert Advisory Team and technical working groups** for each pillar of the national COVID-19 response plan. The Expert Advisory Team provides timely scientific advice for coordinated and informed decision-making process. The COVID-19 technical working groups consist of a multi-disciplinary team from different departments/divisions of the Federal and State Ministries of Health responsible for the implementation and operationalization of the COVID-19 Plan. The working groups report to the NTF with respect to overall work plan implementation status, results framework update, procurement plan status, risk management plan, and escalates implementation bottlenecks for immediate decision and remedial actions.

The PIU at the FMOH will handle all related functions of this SEP, including the appointment of E&S specialists, financial management of the engagement plan, planning, implementation, monitoring and evaluation of engagement event, analyzing GRM input/output, and coordination with all parties in the field, as well as reporting progress and challenges to FMOH senior management and the WB. This SEP will be quarterly updated and upon urgent needs, and accordingly will be aligned with the Project Operation/Implementation Manual.

5. Grievance Redress Mechanism

Grievance Redress Mechanisms (GRMs) can be used as a tool to stay engaged with communities and share information when other direct measures for stakeholder engagement and consultations are more limited during the outbreak of infectious diseases like COVID-19 pandemic.

The existence of the grievance mechanism will be communicated to all stakeholder groups via the channels used to reach these groups for stakeholder consultations, including advertising it in local newspapers and/or local noticeboards. The Project will provide a summary of the implementation of the grievance mechanism to the public on a regular basis, after removing identifying information on individuals to protect their identities.

The main objective of a GRM is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of a broader community consultation that facilitates corrective actions. Specifically, the GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of the project;
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants;
- Avoids the need to resort to judicial proceedings; and
- Allows anonymous grievances to be raised and addressed.

The GRM will acknowledge, investigate and report back to complainants within 7 days. Those who are not satisfied will be guided to the Director General of the State Ministry of Health, and eventually to the Federal Ministry of Health.

The proposed GRM for this project will help health-centered based caseworkers to deal with Sexual Exploitation and Abuse (SEA)/Sexual Harassment (SH) related grievances. As movement of people is limited, and most efforts are focused on supporting healthcare systems, basing a caseworker at a health center is the appropriate option to dealing with GBV. The caseworker will be available at health centers to support both women and girls who are infected with Coronavirus and survivors who report to the hospital. The project will also operate hotlines and WhatsApp communication. This will help to communicate with both survivors and case workers in various parts of the Country and this will help to ensure confidentiality.

5.1. Description of GRM

The GRM aims to address concerns timely, effectively, and in a transparent manner. It is readily accessible for all PAPs. It does not prevent access to judicial and administrative remedies. It is designed in a culturally appropriate way and is able to respond to all needs and concerns of PAPs. A project GRM will have the following key features:

- **Decentralization:** It is critical to take steps to ensure that grievances/appeals can also be submitted at offices closer to complainants' residences. This can be done by enhancing the delegation of powers to the local level to act upon certain types of grievances/appeals. To achieve this: three levels of decision- making are being put in place: local, state, and central (FMOH in Khartoum). Cases will initially be resolved at the local level (health service

providers). For unsolved or unsatisfied cases, the state MOH will take its decision. Cases which are not solved at state level will be solved at the central level. Further, effective communication around the grievance/appeals process will prevent complainants from traveling long distances. These changes will make the GRM system more user-friendly.

- **Multiple Channels:** The activation of multiple channels for submitting grievances/appeals will ensure that complainants do not need to travel to file a complaint, and that different channels can suit the needs of GBV survivors, for instance. This is also being facilitated by allowing online submission of grievances and appeals by using social media platforms (whenever possible).
- **Standardized Processes:** The project will establish of a standardized process for receiving grievances/appeals that assigns clear responsibilities for grievances/appeals management to existing staff and will be included in the GRM manuals. This includes the development of a standardized, simple, and understandable complaint form which could be made widely available.
- **Process Indicators:** the project will collect data to monitor indicators such as resolution rates, average time for resolution, percentage of grievances redressed within stipulated time period, percentage of complainants satisfied with response, and others.
- **Second Appellate Level:** A second level of appeal for complainants that are dissatisfied with the initial response is considered a good practice in grievance management. The project may consider instituting a second level of appeal, as well. The county-level grievance offices will serve for a second appellate level.
- **Communication and outreach:** The project will develop communication material for both offline (e.g., brochures) and online use, including social media channels. The material will describe not only grievance and appeal procedures, but also the objectives of the project and updates on the progress.
- **Capacity Building:** The project will train persons responsible for grievance redress at the locality, state, and national levels on the procedures of the grievance redress mechanism that will be designed and provided. The training will basically help the assigned staff to improve grievances/appeals management, of the project.
- **Complainant Satisfaction:** The project will start and administer a questionnaire to assess the level of satisfaction with the responses received, in line with best practices on grievance management. This can be done by conducting a short survey after each transaction and/or annually through a comprehensive survey, to assess complainant satisfaction levels.

The GRM addresses each area of the feedback value chain:[8] (i) uptake, (ii) sort and process, (iii) acknowledge and follow up, (iv) verify, investigate, and act, (v) monitor and evaluate, and (vi) provide feedback to the complainant to ensure effectiveness (See Figure below).

[8] Each step of the grievance and appeal management process addresses different questions, such as – (i) Uptake; (ii) Sorting and processing; (iii) Acknowledgement and follow up; (iv) Verify, investigate, and act; (v) Monitoring and evaluation(vi) Provide feedback (to the complainants).

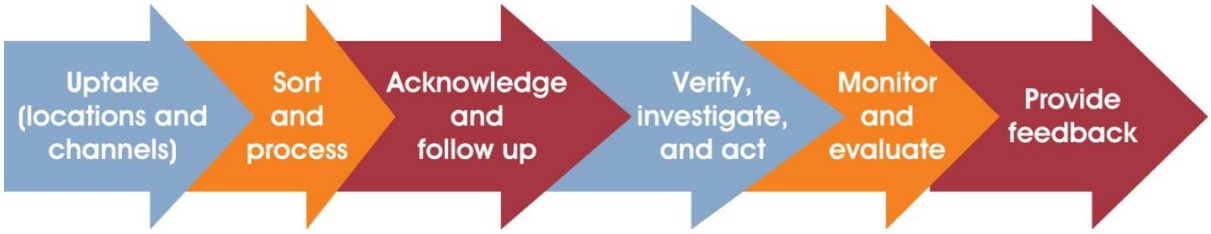

Figure 1: Feedback Value Chain

Cases of GBV/SEA/SH, in particular, can be reported through the general Project GRM. The GBV survivor has the freedom and right to report an incident to anyone: community member, project staff, GBV case manager. All relevant staff of the PIU and implementing agencies will be trained on receiving GBV complains and referral systems, ideally during the project initiation phase and staff onboarding. The GRM officers will be trained on how to receive those cases in an appropriate manner and immediately forward it to the GBV/SEA/SH referral system. The GRM Officer will ensure appropriate response by 1) providing a safe caring environment and respect the confidentiality and wishes of the survivor; 2) If survivor agreed, obtain informed consent and make referrals, 3) provide reliable and comprehensive information on the available services and support to survivors of GBV/SEA/SH.

5.2. Existing GRM System in Sudan

The existing governmental GRM structure, which governs handling of grievance and redress is described as "siloed", and the scope and policy as "differentiated". It is apparent that there is no well-defined and structured GRM process whether on the top of the executive authority, nor in its entities.

However, the only GRM as such has been located at the Council of Ministers as a department. Through this department the PM aim to engage directly with Sudanese citizens by receiving their compliance about the executive authority performance in a high quality and standard that reflects the revolution values as the freedom, social equity and transparency.

Council of Ministers GRM: The idea of this department is correlated with ideals of Sudan's December 19 Revolution for freedom, peace and justice; it shows respect for personal autonomy and accommodates diverse notions of freedom of expression and preferences for disclosure.

Functional Structure: The Functional Structure of this department is as follows:

a. ***Complaints Registration:*** This function is responsible for receiving complaints, information gathering and recording, that includes complainant's personal data. Then the officer is responsible for filing the complaint, who will issue a tracking number for the purpose of monitoring and tracking. The case is submitted afterward to the Analysis Officer.

b. ***Complaints Analysis:*** Data are verified then analyzed in accordance to the law and regulations to identify the complaint's root cause. Some complains could be resolved directly and immediately. For the complex complaints the function/officer will propose an appropriate solution or instruction to the concerned public authority for implementation.

c. ***Complaints Monitoring & Evaluation:*** This function is responsible for liaising various governmental stakeholders and authorities, in which the complaint is relevant to them and intersect with their mandate, particularly in the complex complaints. Also the function is responsible of monitoring the efficiency of implementation of the different activities and

evaluates the impact of the case delivery. Furthermore, the function is responsible of the analyzing the overall efficiency of the Complaints Mechanism.

d. ***Administration:*** The administration function is responsible for all administrative internal procedures and processes that include but not limited to:

- Documentation and archiving;
- Communication between all governmental stakeholders involved in the complaints;
- Complaint registration, closing and result's communication to the complainant; and
- Administrating and operating the complaint system digitally and non-digitally.

5.3. The Proposed GRM

The design of the GRM system will provide means for collecting supportive documents and evidences, investigating the problem, and supporting the final decision. The proposed GRM aims to:

- Reduce fraud, forgery and corruption;
- Increase trust between citizens and the state;
- Increase transparency in procedures;
- Include complainer in the process as part of the solution;
- Circumvent issues before they escalate; and
- Mitigate project risks.

The complaint/grievance, once received, will be promptly resolved or undergo further investigation. Complaints are sorted out according to their complexity. Direct responses will be given to simple inquiries by the concerned staff member in no more than 3-6 working days and will be documented and archived as per the relevant procedure. More comprehensive measures will be applied to complex issues, including field investigation and communicating with higher management (steering committee) for final decisions within a timeframe of 20 working days. The proposed GRM will provide the following process:

1. Complaint Registration

The Officer responsible for receiving complaints (registration officer) will organize the complaint in a form designed for this purpose (see Annex II for a suggested format).

The data will be analyzed and matched with the fieldwork. These data will be used to identify the cause of the underlying problem and to take precautionary measures to avoid future occurrence of the problem. The procedure will also be recorded as a future reference for similar cases.

2. Investigation and Processing of simple complaints – Direct Resolution

Simple complaints, which don't require field investigation, will be addressed directly at the point of issue. In this case, the responsible officer (Registration Officer) will interact with the complainant directly and instantly, will provide necessary explanations, and will take actions accordingly. This would also include the Officer delegating part of, or the whole case to his/her assistant(s), in order to ensure a quicker response, and not overloading higher management unnecessarily.

This type of complaint will be resolved in no more than 3 – 6 working days, which means that the Complainant must get the final answer within a maximum period of 6 days. The complainant will also be notified in case of extension and be informed the reason thereabout. Nevertheless, the duration should not exceed a 10-day time limit including necessary proceedings.

3. Investigation and Processing of complex complaints

This stage of grievance redress involves further investigation and should be considered for the following cases:

- If Registration Officer has already tried to resolve the problem directly, but no satisfactory result was obtained for the Complainant;
- The Complainant directly requested an investigation;
- The issue already requires careful research and investigation; and
- The problem is serious or could result in broader effects.

The duration of this type of complaints is maximum 20 working days, meaning the complainant must be notified of the decision and the action taken within 20 working days from the submission of the complaint. In the case of logical and legitimate reasons for extending the duration, the GRM team should determine the extension, and inform the Complainant accordingly.

4. Closing the Complaint

After the completion of the process, the complaint is closed, and the complaint information is included in the system, including the action(s) taken and the result(s) required. The complainant will be notified of the result and the action taken immediately, and will be informed of the possibility of objecting to the procedure/result. Complainants will have the right to appeal their cases directly to the PIU or to the inter-ministerial steering committee, in case the solution/compensation is deemed unsatisfactory.

5. Dealing with anonymous complaints

All types of complaints will be considered, irrespective of their source, including anonymous complainants, provided that the information contained in the complaint is enough to investigate in the complaint and to take a certain action. All concrete complaints will be considered and submitted to the higher bodies if necessary.

5.4. Roles and responsibilities

The inter-ministerial steering committee will establish a central unit (contacts) reporting to the PIU, and units in the governorates/states, to handle project activity-related complaints. The GRM units will report to the PIU director, and every unit will have three dedicated focal points – Complaints team manager, Investigation Officer, and Registration Officer. The following table presents key roles and responsibilities for running and sustaining a GRM within the project.

Table 3: Proposed GRM roles and responsibilities

Party	Key Roles & Responsibilities
PIU program manager	- Generally supervising the conduct of investigation and processing procedures - Referring of complaints to investigation - Approving results of the investigation and the measures taken - Looking into and advising on submitted appeals
Head of Complaints Team	- Submitting Complaints to the PIU - Directly supervising the investigation and the registration teams - Reviewing and approving the results and procedures - Reporting to the higher management/ steering and technical committees

Party	Key Roles & Responsibilities
Investigation Officer	- Managing the investigation of the complaint - Coordinating with all parties to obtain all necessary information for a complete result - Conducting an integrated investigation, including recommendations for actions - Reporting to the head
Registration Officer	- Registering complaints on paper and electronic formats - Assessing the complexity of the complaint - Prompting actions to the complaints if possible, without referral - Communicating with the Complainant throughout the complaining process - Providing final decisions/ answers and collecting feedback after the issues have been resolved

5.5. Communication Channels

The project will provide multiple access points (hotlines, call centers, complaining boxes, official websites, emails, text messages, etc.) so that grieved people are able to voice their complaints/concerns, using their preferred channel. The contact information of the GRM focal point(s) will be posted in Arabic, and local language as required, on all communication material, at the local level. All complaints received will be registered, tracked, investigated and promptly resolved. Copies of complaints will be recorded in the activity files and the progress reports, including the number, type and actions taken. The table below provides detail on available communication channels for the project GRM.

Table 4: Proposed communication channels for the GRM

Channel	Description
Paper-based	Through the officer in charge (registration officer) at the GRM point in the governorates. Drop boxes will also be provided for paper communication at the locality and state levels.
Telephone/ call centers	On the dedicated complaining telephone number: hotlines All calls will be recorded to ensure transparency Name of the Officer in charge
FMOH website Project link	https://fmoh.gov.sd/index.php/about/contact_us Website section under PIU
Social media accounts	Official Facebook page: https://web.facebook.com/FMOH.SUDAN
Email of project-related complaints	Officer in charge (name)
Submission of appeals	Directly addressed to the PIU manager or the steering committee

5.6. Capacity Building Trainings for GRM Officers

In line with Component 3, and aiming at developing GRM capacities, a training program will be designed and tailored to the needs of the E&S specialist and GRM Officers, who will be assigned to manage grievances/ appeals. This will include detailed modules on topics, such as, receiving,

acknowledging, sorting, referring, monitoring, and reporting on project-related cases, from beneficiaries as well as from non-beneficiaries. As a result, it would be possible then to prepare Standard Operating Procedures (SOPs), work instructions for center and field staff, as well as preparing and integrating complaining forms in the overall information management system. Trainings will be provided at the locality, county, state, and national levels. A training needs assessment will be conducted parallel to establishing the GRM, and will be updated accordingly, to reflect actual needs and those of other responsible staff.

5.7. World Bank Grievance Redress Services

Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

6. Monitoring and Reporting

The SEP will be periodically (quarterly proposed) revised and updated as necessary in the course of project implementation in order to ensure that the information presented is consistent, up-to-date, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Quarterly summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project. The quarterly summaries will provide a mechanism for assessing both the number and the nature of complaints and requests for information, along with the Project's ability to address those in a timely and effective manner.

7. References

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Annex I: Virtual Consultation Meeting – Minutes of Meeting

A consultative meeting regarding the environmental and social impacts of Sudan Covid-19 Emergency Response Project funded by the World Bank

Meeting minutes

Date: 10-3-2021 ***Time: 10:00 am*** ***Venue*: BMR office**

Agenda:

Expert's consultation to highlight the social and environmental impacts of the project and give insights and suggestions on prevention or mitigation measures

Attendees:

Dr. Asia Azrag Dahab – Sanitation coordinator – FMOH, National WASH consultant	Ms. Nagla Omer-MSSD
Dr. Sumaia M. Elsaid,- Associated professor Ahfad University	Nawal Adam Ahmed- planning officer, Planning directorate, FMOH
Dr. Mohamed Salah - Director General of Quality - FMOH	Dr . Abdallah Awad Department – EIA director- Khartoum State Ministry of Health
Dr. Heitham Awadallah – Director General of Curative Medicine - FMOH	Dr. Elkhitma Elawad- Higher council of Environment
Dr. Mohameed Bashir A.Elnair -Director of coordination and partnership- HEEC- FMOH	Dr. Muna Ismail- Project coordinator
Nader Daher - WB	Dr. Salah - WB
Dr. Eman Mukhtar Nasr- Director of bilateral and multilateral relations- GDGH, FMoH	Dr. Manahil Emad- multilateral relations- GDGH, FMoH
Dr. Fatima Mustafa- multilateral relations- GDGH, FMoH	Dr. Khadija- multilateral relations- GDGH, FMoH
Dr. Rawan Mohammed - multilateral relations- GDGH, FMoH	Dr. Azza Tayfour- multilateral relations- GDGH, FMoH

Apologized:

Dr. Babiker Abdalla Ibrahim

Dr. Amal alfatih GDGH_ FMOH

Dr. Mohamed Mustafa Hassan- Director General of Planning and Policy

Opening remarks:

- Dr. Muna and Dr. Salah introduced themselves and welcomed the attendees. Dr. Muna gave a briefing about the project (overall funds, objectives, components and timeline), mentioning the agenda of the meeting.
- The attendees introduced themselves.

Discussion points:

- Mr. Nader highlighted the social and environmental impacts of the project and the importance of public engagement/consultation in the policy of WB Projects.
- Dr. Sumia and Dr. Khatima inquired about the method of public consultation, regarding the use of Facebook and if there will be any further engagement of other communities or sectors. Dr. Khatima also inquired if there were any environmental and social assessment done previously. Mr. Nader answered and justified the whole process of consultations and the engagement of the public/ communities from the perspective of the WB, where he stated that this consultation will be an ongoing process throughout the project. Mr. Nader justified the use of the virtual meetings and online questionnaire to the restrictions due to COVID-19 and the emergency status. He also noted the safeguard instruments that will be developed for the project: including labor protection and management procedures.
- Dr. Asia was concerned about the medical waste and the safety of healthcare workers. She stated that there should be a plan for safe disposal of wastes from all isolation and health centers. The guidelines are in place but there are challenges in implementation including availability of resources and adequate training. Most hospitals do not have in-house incinerators. They have direct responsibility to safely dispose any medical waste inside the hospital. Outside the hospital, this is the responsibility of Higher Council of Environment and localities. Mr. Nader explained the concerns of the WB regarding the residual impact (medical wastes, impact on the healthcare workers) and inquired about the regulations of the national system regarding the healthcare workers and proper waste disposal.
- Dr. Sumia talked about the community acceptance of the vaccine, concerns on side effects and satisfaction, the role of media, criteria of choosing the vaccines groups, giving an example of Qatar national vaccination program and finally about the economic impacts: cost benefit and cost of the vaccines. Dr. Khatima reflected on Dr. Sumia's suggestions to learn from other countries' experiences and she also reflected the importance of awareness. Raising awareness needs to be given good attention in this project and there is a need to find innovative ways. Mr. Nader answered both of the questions, reinforced the use of media and social media to raise the awareness and that it is normal for some hesitancy to exist in taking the vaccine and that rumors and misinformation needs to be addressed.
- Dr. Mohammed Salah explained the policy of prioritization of the vaccines distribution, the use of the WHO scoring system according to age, and comorbidities. Four states that have highest number of cases are prioritized: Khartoum, Gezira, Red state and Gedarif.
- Dr. Mohamed Salah also explained the first phase of the vaccine distribution in Sudan. The first phase will prioritize frontline health care workers specifically those who are working in isolation centers, not only because they are at highest risk but because they are main spreaders

of the disease. The other priority group are those above 45 who have co-morbidities. This age group was chosen, as according to the last census, Sudan is mainly a young population. The current country policy is that the vaccine is free of charge. As part of COVAX, the country is expecting a second shipment and further groups will be added to criteria (for example teachers).

- Dr. Khitma asked about the type of vaccines, their efficiency and safety. Dr. Mohamed Salah replied that currently the Vaccine available from Covax, manufactured from AstraZeneca British-Swedish multinational pharmaceutical and Biotechnology Company, it was launched yesterday on Tuesday (9-3-2021).
- Mr. Nader emphasized the importance of social impact of the project, and the possibility of social engagement by campaigns, digital media and other tools because community inclusion is important to ensure the project acceptance.
- Mr. Nader explained the GRM Grievance Redress Mechanism and suggested its use to save the rights of community.
- Dr. Salah asked about the waste management of vaccines where Dr. Asia explained the strategy of waste management 2009 and 2014. She also mentioned the issue of incinerator availability and the urgent need of capacity building.
- Dr. Sumia suggested adding a framework for risk management.
- Dr Abdallah suggested a focus group discussion for further public consultation.
- Mr. Nader presented the Facebook consultation questions.
- There was a discussion on concerns of child labor. Due to school closures during COVID-19, many children dropped out of school and started working. These children are at risk of being exploited.
- Dr. Mohammed Bashir highlighted the importance of capacity building as a part of this project (STACK Medical Research Laboratory).
- Dr Abdallah talked about the possibility of a current third wave in Sudan.

Dr Mohammed Bashir replied that by indicators there is no confirmation but by observation, there are signs that there is a start of a third wave.

- Dr. Salah thanked the attendees.
- Dr. Muna concluded the meeting.

Annex II: Sample Grievance Registration Form

The _____Project welcomes complaints, suggestions, queries and comments regarding project implementation. We encourage persons with grievance to provide their name and contact information to enable us to get in touch with you for clarification and feedback.
Should you choose to include your personal details but want that information to remain confidential, please inform us by writing/typing *(CONFIDENTIAL)* above your name. Thank you.

Date		**Place of Registration**			
Contact Information/Personal Details					
Name		**Gender**	* Male * Female	**Age**	
Home Address					
Place					
Phone no.					
E-mail					
Complaint/Suggestion/Comment/Question Please provide the details (who, what, where, and how) of your grievance below: If included as attachment/note/letter, please tick here:					
How do you want us to reach you for feedback or update on your comment/grievance?					

FOR OFFICIAL USE ONLY

Registered by: (Name of Official Registering Grievance)	
Mode of Communication: Note/Letter E-mail Verbal/Telephonic	
Reviewed by: (Names/Positions of Officials Reviewing Grievance)	
Action Taken:	
Whether Action Taken Disclosed:	Yes No
Means of Disclosure:	